MaineCare Services
An Office of the
Department of Health and Human Services
Paul R. LePage, Governor
Mary C. Mayhew, Commissioner

Supplemental Genetic Testing Prior Authorization Form

Department of Health and Human Services
MaineCare Services
Prior Authorization Unit
11 State House Station
Augusta, Maine 04333-0011
Tel: 1-866-690-5585
Fax: 1-866-598-3963

Prior Authorization Number*	**Member Name** (Last Name, First Name)	**Member I.D. Number**

Why is this procedure necessary for this member? (Please include member's medical diagnosis and log in to https://mainecare.maine.gov under the Provider tab; then click on Prior Authorization to review the Genetic Testing Services criteria sheet). Please be as specific as possible with regard to the clinical circumstances and purpose of the genetic testing service. Add additional pages as necessary.

1. Clinical justification statement. Describe the appropriateness and medical utility of this test as compared to alternative laboratory or clinical tests. Include justification based on medical, family, psychosocial histories and/or prior personal, family, or reproductive partner testing. In general, diagnostic genetic testing for a disease should be performed once in a lifetime. However, when warranted, documentation should support the medical necessity and clinical utility of serial testing based on medical records and literatures.

2. This genetic testing service is medically necessary for the following reasons (must check one):

Diagnostic testing if a member is experiencing symptoms of or demonstrating findings consistent with a disease that may be caused by genetic alterations.	☐ Yes	☐ No
Pre-symptomatic and pre-dispositional predictive testing for members with a documented family history of a genetic disorder.	☐ Yes	☐ No
Pharmacogenetic testing for medical conditions if the results will help inform clinical therapeutic decision-making.	☐ Yes	☐ No
Genetic carrier screening/testing if a member or member's partner has a family history of a genetic disorder, including risk based on belonging to certain ethnic groups who are at increased risk of having children with certain genetic disorder (e.g. cystic fibrosis, Ashkenazi disease screen, sickle cell disease and other hemoglobinopathies).	☐ Yes	☐ No
Prenatal screening and diagnostic genetic testing to detect some types of abnormalities in a fetus' genes.	☐ Yes	☐ No

3. Recognized as standard medical care, based on national standards for best practices and safe, effective, quality care.

This genetic testing service(s) is/are ordered by a physician or other licensed practitioner of the healing arts authorized to order lab services within the scope of his or her license and is consistent with good medical practice and based on evidence-based criteria and national standards.	☐ Yes	☐ No	
*Please note: If requested, please be prepared to provide at least one (1) reference to peer-reviewed literature and/or guidelines from an American medical society that supports the genetic testing order.			
If this test is for *BReast CAncer susceptibility gene (BRCA) screening*, the test is being order in accordance with recommendations from the United States Preventive Services Task Force: [http://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/brca-related-cancer-risk-assessment-genetic-counseling-and-genetic-testing].	☐ Yes	☐ No	☐ N/A
If this test is a carrier screening for cystic fibrosis, spinal muscular atrophy, or Fragile X Syndrome, it is being ordered in accordance with the recommendations from The American College of Obstetricians and Gynecologists [http://www.acog.org/].	☐ Yes	☐ No	☐ N/A

ATTESTATION

I have reviewed the MaineCare Clinical Criteria for this request. Pursuant to Chapter I, Section 1.03-3 Subsection M, the Department regards adequate clinical records as essential for the delivery of quality care. Such comprehensive records are key documents for post-payment review. Your authorization certifies that this request is medically necessary, meets the MaineCare criteria for prior authorization, does not exceed the medical needs of the member, and is supported in your medical records.

Provider Signature: _____ Date of Submission: _____

PRINT Provider Name: _____

If submitting via web portal or AVRS, enter PA number assigned; otherwise, leave blank.